RECORD AND BRIEFS

No. 14-15

Supreme Court, U.S.
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In The
Supreme Court of the United States

RICHARD ARMSTRONG and LISA HETTINGER,

Petitioners,

v.

EXCEPTIONAL CHILD CENTER, INC.; INCLUSION, INC.; TOMORROW'S HOPE SATELLITE SERVICES, INC.; WDB, INC.; and LIVING INDEPENDENTLY FOR EVERYONE, INC.,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

REPLY IN SUPPORT OF PETITION FOR A WRIT OF CERTIORARI

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I. RESPONDENTS ARE WRONG WHEN THEY CONTEND THAT THE RECORD IS INSUFFICIENT TO PERMIT ADEQUATE REVIEW OF THE QUESTIONS PRESENTED

Respondents say that this case is not an appropriate vehicle to address the questions presented in the petition because the facts are insufficient to permit appropriate review of them. Brief in Opposition 5. The centerpiece of this argument is a waiver amendment application Idaho submitted to the Centers for Medicare and Medicaid Services in 2009 to update the method of setting reimbursement rates to include criteria required by Idaho Code § 56-118. This waiver amendment had nothing to do with the case as pleaded, litigated, or decided in the courts below. It does not bear on the questions whether the Supremacy Clause gives providers a private right of action to enforce § 30(A) or whether reimbursement rates are preempted by § 30(A) if they do not bear some relationship to provider costs and remain in place for budgetary reasons.

Brief elaboration on the facts is in order. The lone reference in the stipulation of facts to the 2009 waiver amendment was that the State "sought CMS approval of an amendment to the DD Waiver to change the method of setting reimbursement rates." Reply App. 7. Appendix I-2.a. of the waiver amendment directs the State to "describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination." Reply App. 15. The 2009 waiver amendment – which was not even

effective until after Respondents filed suit[1] – describes for CMS the criteria required by Idaho Code § 56-118 to be considered as part of the rate setting process. Reply App. 16-17. And here is where Respondents go wrong: They contend now that the waiver amendment application, CMS's decision on it, and how it was implemented was never discussed by the courts below. The argument goes that this waiver amendment is relevant to both questions presented, but that the record leaves too much unknown to justify this Court's review. Brief in Opposition 7-8. This argument rests on a faulty premise that § 56-118 and the waiver amendment are tied to the rates they challenged.

In short, Respondents' arguments seek to make relevant something that never was in this case. Respondents challenged the State's rates as too low based on new provider cost information derived from studies the State conducted following enactment of § 56-118. Pet. App. 21. Neither § 56-118 nor the 2009 waiver amendment would have necessarily affected rates. Section 56-118 expressly stated that the process that statute mandated did not guarantee any change in rates.[2] Reply App. 13. The waiver amendment giving

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[1] The complaint was filed on December 7, 2009. The waiver amendment they complain about was not even effective until December 16, 2009. Reply App. 15.

[2] Respondents' assertion that Idaho Code § 56-118 required rates to be based on the "actual cost of providing quality services" (Brief in Opposition 20) is therefore belied by the plain language of the statute.

CMS notice of the requirements established by § 56-118 did not specify or necessitate a rate change, either. The waiver amendment did not propose to adopt the 2009 rates. The Department of Health and Welfare conducted the studies, continued to refine the methodology, and reported the results of those studies to the Legislature each year. Any change in rates was left to the Idaho Legislature to decide whether to appropriate funds for any increases. Reply App. 12-13.

In other words, study and consideration of provider costs in the manner prescribed by § 56-118 and identified in the waiver amendment does not mean that rates will automatically be adjusted upward to match those produced by the studies. This is entirely consistent with § 30(A) and the CMS regulations regarding reimbursement. Section 30(A) requires only that state plans, or in this case, waivers, provide "methods and procedures" that are sufficient to ensure efficiency, economy and access to quality care. Nothing in § 30(A) requires granular specificity. Under the general methods and procedures set forth in waiver documents, states retain significant discretion to hone the fine details of rate-setting and to set and adjust rates without the need for CMS approval. *See* 42 C.F.R. § 447.203 (requiring states to document rates and to make them available to CMS on request).[3] Rates are driven by compliance with § 30(A);

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[3] Waiver services are subject to a cost-neutrality requirement, meaning that the average per-capita expenditure for waiver services may not exceed 100 percent of the average per-capita

(Continued on following page)

they are the product of many inputs. Provider cost is one of them. Regardless of the criteria considered, rates may go up or down to ensure compliance with § 30(A).

CMS's decision on the 2009 waiver amendment application therefore does not bear on the questions whether the Supremacy Clause provides a private right of action to enforce § 30(A) or whether the State's rates were preempted by § 30(A) in light of cost information indicating costs had risen. Respondents, however, use the 2009 waiver amendment to consign this case to the same procedural position as *Douglas v. Independent Living Center, Inc.*, 132 S. Ct. 1204 (2012). Brief in Opposition 7-9. There is a key procedural difference between *Independent Living Center* and this case. Following oral argument in *Independent Living Center*, CMS approved California's state plan amendment containing the rate cuts that the plaintiffs challenged. CMS's decision constituted final agency action under the Administrative Procedure Act, 5 U.S.C. § 701, *et seq.* The Court thus remanded for consideration of whether CMS's decision meant the plaintiffs there had to seek review under the APA against the Secretary of the Department of Health and Human Services rather than against California under the Supremacy Clause. 132 S. Ct. at 1211.

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expenditures that would have been made in hospitals, nursing or other facilities. *See* 42 U.S.C. § 1915(c)(2)(D); 42 C.F.R. 441.302(e).

Here, though, nothing about the 2009 waiver amendment affects either question. As this case was litigated in the courts below and as it comes to this Court, it is a challenge brought under the Supremacy Clause to enforce § 30(A) on the contention that the State's rates are too low because they do not reflect provider costs. This case was not about the 2009 waiver amendment or the State's compliance with it. The complaint makes no mention of the 2009 waiver amendment. The waiver amendment is not in the district court record. Neither the district court nor the court of appeals discussed it. Respondents' contention, therefore, that they sued because the State failed "to actually implement the rate-setting methodology set out in the waiver amendment" (Brief in Opposition 3), is incorrect. Indeed, Respondents agree that CMS's decision on the 2009 waiver amendment was not deemed relevant in the district court. Brief in Opposition 8. They are right about this. This case is and always has been about whether the State's rates violated § 30(A) and whether Respondents had a right of action to bring that challenge. The relevant facts remain as summarized in the petition. The waiver amendment has no relevance now, just as it has not been relevant at any stage in the case.

II. THE QUESTION WHETHER THE SUPREMACY CLAUSE PROVIDES A PRIVATE RIGHT OF ACTION TO ENFORCE § 30(A) IS APPROPRIATE FOR THIS COURT'S REVIEW

Respondents acknowledge there is a split of authority in the circuits on the Supremacy Clause question, but nevertheless urge the Court to deny the petition because according to them, the split is not the sort of split that this Court should resolve. Brief in Opposition 10-15. They argue that the Tenth Circuit's decision in *Planned Parenthood of Kansas and Mid-Missouri v. Moser*, 747 F.3d 814 (10th Cir. 2014), does not constitute a decision worth counting as forming part of a split – it is too new and too narrow; more time is necessary to allow this issue to resolve itself. Brief in Opposition 13-14.

Respondents characterize the holding in *Moser* as "complicated and narrow," applying in only "extremely limited circumstances." Brief in Opposition 13. Their characterization of *Moser* is wrong. The Tenth Circuit's decision in *Moser* stands as a direct and clear and thorough rejection of the approach followed by the Ninth Circuit and the other circuits on that side of the split. *See* 747 F.3d at 836 n.7. And *Moser*'s four-part test that Respondents say makes the holding "complicated and narrow" is neither and in fact plainly would control this case in a post-*Moser* Tenth Circuit: (1) § 30(A) does not specifically authorize injunctive relief; (2) it does not create an individual right; (3) it is a Spending Clause statute; and (4) the State is not conducting or threatening to

conduct criminal or civil enforcement proceedings against the Respondents. *See id.* at 817.

Split or no split, Respondents contend that Petitioners are asking the Court to depart from its cases which they suggest have permitted Supremacy Clause preemption cases like this one without requiring that the standards for establishing a cause of action under 42 U.S.C. § 1983 be met. They claim, too, that under Petitioners' theory, even *Ex parte Young*, 209 U.S. 123 (1908) would not satisfy the standard. Neither of these arguments is correct.

First, the Medicaid Act is Spending Clause legislation – a fact to which Respondents incorrectly assign no significance. This Court has said that Spending Clause legislation "is much in the nature of a contract." *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981). The "typical remedy for state noncompliance with federally imposed conditions is not a private right of action for noncompliance but rather action by the Federal Government to terminate funds to the State." *Id.* at 28. So, "unless Congress 'speak[s] with a clear voice,' and manifests an 'unambiguous' intent to confer individual rights, federal funding provisions provide no basis for private enforcement." *Gonzaga Univ. v. Doe*, 536 U.S. 273, 280 (2002), *quoting Pennhurst*, 451 U.S. at 17, 28 & n.21. In *Maine v. Thiboutot*, 448 U.S. 1 (1980), the Court explained that if there is to be a cause of action to enforce Spending Clause legislation, § 1983 is "necessarily the exclusive statutory cause of action." 448 U.S. at 6. Where Congress has

not created enforceable rights under the statute in question and § 1983 is therefore unavailable, an implied Supremacy Clause preemption claim to enforce § 30(A) does not square with this Court's cases.

Second, Petitioners are not suggesting *Ex parte Young* and the line of cases following it should be undone or even tampered with. That case involved "the preemptive assertion in equity of a defense that would otherwise have been available in the State's enforcement proceedings at law." *Virginia Office for Prot. & Advocacy v. Stewart*, 131 S. Ct. 1632, 1642 (2011) (Kennedy, J., concurring). Like *Independent Living Center*, this is not an *Ex parte Young* case. Respondents do not contend that their conduct is subject to any criminal or civil enforcement proceeding. They do not contend that the rates somehow interfere with a federally conferred right. They simply seek to enforce a statute for which Congress did not provide a right of action. *See, e.g., Independent Living Ctr.*, 132 S. Ct. at 1213 (Roberts, C.J., dissenting) ("[T]he respondents are not subject to or threatened with any enforcement proceeding like the one in *Ex parte Young*. They simply seek a private cause of action Congress chose not to provide.").

* * *

In *Independent Living Center*, the Supremacy Clause question was appropriate for review even before there was an appellate-court split on the question. *See* Brief of Texas, *et al.* as *Amici Curiae* 3. Since *Independent Living Center* the Fifth and Ninth

Circuits have reaffirmed their prior holdings on the question; the Tenth Circuit and the Supreme Judicial Court of Massachusetts have rejected the view of those courts. (Respondents omit any discussion of *Boston Med. Ctr. Corp. v. Sec'y of the Executive Office of Health & Human Servs.*, 974 N.E.2d 1114 (Mass. 2012) (no Supremacy Clause cause of action to enforce § 30(A) in state court).) The Seventh Circuit has called the existence of a right of action under the Supremacy Clause "highly doubtful." *Planned Parenthood of Ind., Inc. v. Indiana State Dep't of Health*, 699 F.3d 962, 983 (7th Cir. 2012). The split is entrenched. It reflects differing views of this Court's cases. Clarity on this question now is critical for states. Nothing is to be gained from delaying review of this issue.

III. QUESTION TWO WARRANTS REVIEW: THERE IS A CIRCUIT SPLIT AND RULEMAKING IS UNLIKELY TO RESOLVE THE ISSUE

Respondents oppose review of the second question for two reasons: (1) There is no longer any split because the Ninth Circuit's view on § 30(A) has "evolved"; and (2) CMS will finalize rulemaking regarding § 30(A) in the near term, resolving all of the issues the question presents.

There is still a split. *Managed Pharmacy Care v. Sebelius*, 716 F.3d 1235 (9th Cir. 2013), does not represent the evolution in approach that Respondents claim. In *Managed Pharmacy Care*, plaintiffs sued

both the Secretary of the Department of Health and Human Services in an APA action and California under the Supremacy Clause, challenging CMS's decision to approve California's Medicaid provider reimbursement rate reductions and challenging the state statutes authorizing them. 716 F.3d at 1240. The Ninth Circuit held that where the Secretary approved a state plan amendment that did not require California to conduct the cost studies required by *Orthopaedic Hospital v. Belshe*, 103 F.3d 1491 (9th Cir. 1997), the decision was entitled to deference and would stand. *Id.* at 1250. *Orthopaedic Hospital* did not control specifically because in that case the Secretary was not a party and had not set out HHS's position on the requirements of § 30(A). *Id.* at 1245. In *Managed Pharmacy Care*, by contrast, the Secretary was a party and had specifically approved the rate cuts.

The Ninth Circuit recently issued a decision affirming *Orthopaedic Hospital* and limiting *Managed Pharmacy Care*. The result is that *Managed Pharmacy Care* only applies when the challenged state policy was specifically approved by CMS. When a plaintiff challenges a state's policy or decision affecting reimbursement that was not specifically approved by CMS, as here, *Orthopaedic Hospital* still applies, and states must study the effect of its policy changes on efficiency, economy, and access to quality care. In *The Arc of California v. Douglas*, No. 13-16544, 2014 WL 2922662 (9th Cir. Jun. 30, 2014), the court invalidated two California statutes affecting

reimbursement for certain services provided under its Home and Community Based Services waiver. The first, the "uniform holiday schedule" (enacted 2009), precluded compensation for many waiver services rendered on 14 specific dates in the year. *Id.* at *3. The second, the "half-day billing rule" (enacted 2011) required providers to seek reimbursement for only a half day of service, as opposed to a full day, if they provided care for less than 65 percent of a day. Neither rule had been preceded by a study of the impact of those rules on efficiency, economy, and access to quality care. *Id.* at *11. California sought and obtained approval of a waiver renewal application for its waiver covering the period 2011 to 2016. *Id.* The district court applied *Managed Pharmacy Care*, ruling that CMS had approved the waiver application and so the rules were consistent with § 30(A). *Id.* But the Ninth Circuit reversed, noting that the waiver renewal application did not include the uniform holiday schedule or the half-day billing rule. *Id.* Because CMS did not have this information in evaluating the waiver renewal application, it could not have approved it.[4] *Id.* No deference was due, and by not

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[4] The court identified what it called a second reason for declining to defer to HHS's approval of the waiver renewal. It said that the state's failure to include information about the uniform holiday schedule and the half-day billing rule "reflects the scope and purpose of the [Home and Community Based Services] waiver application process." *Id.* at *11. The court explained that in reviewing waiver renewals, the Secretary considers the waiver requirements, not the "separate, more generally applicable state plan requirements," like § 30(A). *Id.*

studying the impact of its policies on § 30(A), California had "total[ly] abdicat[ed]" its obligations under that statute as required by *Orthopaedic Hospital*. *Id.* at *12.

Respondents also argue that CMS has adopted new regulations and that more are "likely to be finalized this year" that will clarify what is required under § 30(A). Brief in Opposition 25. They cite January 2014 amendments to 42 C.F.R. § 441.304(e) and (f), but they do not explain how these have any relevance to the question whether rates must bear some relationship to provider costs and whether they must be raised to reflect those costs. These subsections address notice and public participation to be provided when substantive changes are made to an HCBS waiver. They say nothing about compliance with § 30(A) and have no relevance to this case.

Finally, the status of the May 2011 rulemaking that would address compliance with § 30(A) is no more clear than it has been in the three-plus years since it was proposed. The website Respondents cite lists November 2014 as the date for final action on the rule, but provides no other information. Typically, when CMS is proposing a rule, it will communicate with states and states will be aware that a rule is likely to be finalized. Idaho has no information suggesting the rulemaking will be finalized by November 2014. Regardless of the status of the rule, however, Petitioners are not asking this Court to interfere with whatever CMS might adopt. Petitioners ask the Court to grant the petition as to this question to

decide the extent to which federal courts may impose on states requirements that do not appear in the Medicaid Act.

* * *

The petition should be granted.

Respectfully submitted,

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IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

INCLUSION, INC., EXCEPTIONAL CHILD CENTER, INC., LIVING INDEPENDENTLY FOR EVERYONE, INC. TOMORROW'S HOPE SATELLITE SERVICES, INC., WDB, INC.,	Case No. 09-CV-00634-BLW
Plaintiffs,	STIPULATION OF FACTS
v.	
RICHARD ARMSTRONG, and LESLIE CLEMENT, in their official capacities,	
Defendants.	

COME NOW Defendants Armstrong and Clement, by and through their attorneys of record, and the above-named Plaintiffs, by and through their attorney of record, and hereby stipulate and agree to the following facts:

I. The Parties

1. Plaintiffs are five Idaho corporations providing services to Medicaid eligible individuals in the state of Idaho.

2. Defendant Richard Armstrong is the Director of Idaho's Department of Health and Welfare (IDHW). Defendant Leslie Clement is an IDHW Deputy Director and former IDHW Division of Medicaid Administrator with responsibility for administering and operating Idaho's Medicaid Plan at all times relevant to this litigation.

II. Services Provided by Plaintiffs That are the Subject of this Lawsuit

1. Medicaid is a cooperative federal-state program that directs federal funding to participating states to "enable[e] [sic] each state, as far as practicable to furnish medical assistance on behalf of families with dependent children and of aged, blind and disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services." 42 U.S.C. §1396-1. Should a state choose to participate in the Medicaid program, it must comply

with the requirements of the Medicaid Act. The State of Idaho has chosen to participate in the Medicaid program.

2. Idaho's Medicaid-covered services are set out in the Medicaid state plan. The State of Idaho also covers certain Medicaid benefits pursuant to waivers approved by the Federal Center for Medicaid and Medicare Services ("CMS"). One such waiver is known as the Developmentally Disabled Home and Community Based Services Waiver ("DD Waiver").

3. Pursuant to the DD Waiver, individuals who qualify to receive medical assistance and rehabilitation services under the Idaho Medicaid state plan and who also meet institutional level of care requirements to receive care in an Intermediate Care Facility for People with Intellectual Disabilities ("ICF/ID") may choose to reside in either their own home and receive Supported Living services or in a Certified Family Home ("CFH"). *See* IDAPA 16.03.10.702.03.

4. Plaintiffs in this case are Residential Habilitation Agencies (RHA) providing Residential Habilitation in Supported Living settings.

5. Residential Habilitation consists of an integrated array of individually-tailored services and supports which are designed to assist eligible participants to reside successfully in the community. These services and supports are set forth in IDAPA 16.03.10.703 and include skills training and/or direct assistance in areas such as decision making, money management, daily living skills, socialization,

mobility and behavior shaping or management. Residential Habilitiation [sic] also includes personal assistance services to the participant in daily living activities, household tasks, and routine activities which the individual is unable to accomplish on his or her own, including grooming, bathing, eating, administering medications that are normally self-administered, communication, cleaning, laundry, meal preparation, shopping and the like. Residential Habilitation may also include skills training for participants, their family members and other caregivers.

III. Reimbursement Rates for Residential Habilitation Services/Supported Living

1. Each RHA wishing to offer services reimbursed by Medicaid must execute a Medicaid Provider Agreement. One of the terms of the Medicaid Provider Agreement is that the provider must accept Medicaid reimbursement as the total payment for covered services. Each of the Plaintiffs has executed one or more provider agreements.

2. From March 2001 through November 2002, supported living services provided under the DD Waiver were reimbursed at an hourly rate with an effective cap of $202.60 per day.

3. Effective September 1, 2003, at the request of RHAs providing supported living service and developmental disability agency services, such as developmental therapy, IDHW instituted a "wrap around" service and reimbursement rate. Under the wrap

around service, providers could be reimbursed a daily rate of $242.14 per day for all residential habilitation and supervisory services provided to residents in supported living.

4. Effective October 1, 2004, following onsite observation of participants and survey of RHAs, IDHW initiated acuity based levels of care, and changed reimbursement for wrap around services to $221.12 per day for residents requiring a "High Support" level, and $263.36 per day for residents requiring "Intense Support."

5. Effective July 1, 2006, the IDHW modified the wrap around service rates, changing "High Support" rate to $225.32 per day, and the "Intense Support" rate to $268.36. At the same time, rates for supported living services that were billed on an hourly basis were increased to $12.96 per hour for individual services, and $7.64 per hour for group services. These rates are still effective today.

IV. The IDHW's Studies of Costs for Supported Living Services

1. In 2005 the Idaho Legislature adopted Idaho Code Section 56-118 requiring the IDHW to implement reimbursement rate setting methodologies for various Medicaid services including residential habilitation agency services. As part of its efforts to comply with I.C. §56-118 the IDHW contracted with Johnson, Villegas-Grubb and Associates ("JVGA") to assist in establishing a methodology for reviewing

and determining Medicaid reimbursement rates to private businesses providing community-based services.

2. The first report from JVGA was submitted to the Idaho Legislature on November 30, 2006. JVGA's first report was the result of a survey of Medicaid providers to determine their costs of providing service. Utilizing what JVGA called the "Arizona Model," a proposed reimbursement rate for each service was calculated utilizing a direct service wage component, with additions calculated as a percentage of direct service wages for Employment Related Expenditures, Program Related Expenditures, and General and Administrative Expenses. The JVGA report recommended the following changes in reimbursement rates for residential habilitation services in a supported living environment:

Description	2006 Rate	JVGA Proposed Rate	% Change
Daily Rate – High Support	$225.32	$228.48	1.4%
Daily Rate – Intense Support	$268.36	$342.72	27.7%
Hourly Rate – Individual	$12.96	$18.72	44.3%
Hourly Rate – Group	$7.64	$7.48	-2.1%

3. The IDHW did not modify residential habilitiation [sic] reimbursement rates as proposed by JVGA, but continued to conduct cost and time studies. The results of the IDHW's studies were reported to the Legislature each year.

4. In 2009, the IDHW compiled the results of its cost studies over the preceding years, made modifications to the "Arizona Model" as proposed by JVGA, and sought CMS approval of an amendment to the DD Waiver to change the method of setting reimbursement rates. The IDHW created a "Summary of Service Codes" based on the available studies which calculated proposed reimbursement rates for certain services based on wage rates, employment related expenditures, program support expenses, paid leave time and general and administrative expenses. The IDHW's 2009 calculation was part of its report to the legislature under I.C. §56-118. The following is a comparison of the 2006 Rates, the JVGA Proposed Rates and the IDHW's 2009 calculations:

Description	2006 Rate	JVGA Proposed Rate	IDHW's Proposed 2009 Rate
Daily Rate – High Support	$225.32	$228.48	$248.40
Daily Rate – Intense Support	$268.36	$342.72	$496.56
Hourly Rate – Individual	$12.96	$18.72	$20.68
Hourly Rate – Group	$7.64	$7.48	$8.28

5. The IDHW has not implemented the rates set out in the 2009 calculation for the services at issue in this case.

6. Sheila Pugatch is the Principal Financial Specialist at IDHW. She manages the Office of Reimbursement Policy, which has primary responsibility for setting Medicaid reimbursement rates.

7. Ms. Pugatch directed the IDHW's efforts to conduct cost studies and to calculate proposed reimbursement rates, including the IDHW's 2009 rate proposals. In addition, Ms. Pugatch oversaw the efforts of JVGA to collect and analyze cost data. The result of the JVGA proposal on rates would have been a $4 million increase in state Medicaid expenditures, If the Legislature had appropriated additional funds, the IDHW intended to implement the JVGA proposed rates. The Legislature did not, however, appropriate funds for those increases.

8. The present rate, implemented in 2006, is not based on the cost studies performed between 2006 and 2009. The IDHW would implement the rates set out in the 2009 legislative report if the Idaho Legislature would appropriate the funds to pay them. In the absence of an appropriation, the IDHW has not implemented those rates.

V. Access to Supported Living Services

1. Services covered by the DD Waiver are readily available to eligible participants. There are

no waiting lists for any Medicaid services in Idaho. If a DD Waiver participant chooses to live in their own home and receive supported living services, the participant's service coordinator and care manager assist with providing the participant RHAs in the geographic area to choose from.

2. Currently there are 61 RHAs certified to provide supported living services in Idaho. The following table shows the number of RNAs providing supported living services in each of IDHW's seven regions throughout the state:

Region 1 = 5
Region 2 = 7
Region 3 = 9
Region 4 = 14
Region 5 = 7
Region 6 = 9
Region 7 = 10

3. There are 6,202 participants receiving supported living services. As of the end of calendar year 2010 Plaintiffs submitted claims for supported living services for the following number of participants:

Provider	# of Participants	% of Total
Inclusions Inc.	138	2.2%
Excepitonal [sic] Child Center, Inc.	10	.16%
Living Independently For Everyone, Inc.	36	.6%
WDB, Inc.	38	.61%
Total Plaintiffs	222	3.5%

4. The IDHW Critical Incident and Complaint Data Base, used to track all Medicaid benefits and services complaints, including complaints related to access to services, shows no unresolved complaints for supported living services.

5. Jim Whitaker, Operations Director for Plaintiff Inclusions, Inc., testified that Inclusions, Inc. had not ever turned away a prospective client because it could not afford to provide supported living services.

6. James Hutchings, Administrator and owner of Exceptional Child Center, Inc. testified that his agency could take on at least two more supported living clients. To his knowledge his agency had not ever turned away a supported living client.

DATED this 25th day of July, 2011,

HERZFELD & PIOTROWSKI

/s/
JAMES M. PIOTROWSKI
Attorney for Plaintiffs

DATED this 25th day of July, 2011.

OFFICE OF THE
ATTORNEY GENERAL

/s/ Peg M. Dougherty
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Attorney for Defendants

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 25th day of July, 2011, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system and serviced a copy of said document upon all parties by the method listed below:

Attorneys for Plaintiffs
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/s/ Peg Dougherty
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IDAHO CODE 56-118. REIMBURSEMENT RATES. (1) The department shall implement a methodology for reviewing and determining reimbursement rates to private businesses providing developmental disability agency services, mental health services, service coordination and case management services, residential habilitation agency services and affiliated residential habilitation specialized family home services annually.

(2) In addition to any policy or federal statutory requirements, such methodology shall incorporate, at a minimum, the following:

(a) The actual cost of providing quality services, including personnel and total operating expenses, directly related to providing such services which shall be provided by the private business entities;

(b) Changes in the expectations placed on private business providers in delivering services;

(c) Inflationary effects on the private business providers' ability to deliver the service since the last adjustment to the rate;

(d) Comparison of rates paid in neighboring states for comparable services;

(e) Comparison of any rates paid for comparable services in other public or private capacities.

(3) A report of the results of this analysis and review shall be sent to the director, to the joint finance-appropriations committee and the health and welfare

committees of the senate and the house of representatives by November 30 of each year. The department shall include in the report cost saving suggestions that private businesses shall provide. Any changes in reimbursement rates shall include estimated costs of implementation based on the current caseload forecasts and shall be submitted as part of the departments budget request required in section 67-3502, Idaho Code. Reimbursement rates included in appropriation bills enacted by the legislature shall become effective not later than July 1 of each year.

(4) The results of this annual review and analysis and subsequent rules do not guarantee a change in reimbursement rates, but shall be a fair and equitable process for establishing and reviewing such rates.

Approved on the 21st day of March, 2005.

Effective: July 1, 2005.

Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **Idaho** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. **Program Title:**
Idaho Developmental Disabilities Waiver (renewal)

C. **Waiver Number:ID.0076**
Original Base Waiver Number: ID.0076.90.R3B

D. **Amendment Number:ID.0076.R04.03**

E. **Proposed Effective Date**: *(mm/dd/yy)*

12/16/09

Approved Effective Date: 12/16/09
Approved Effective Date of Waiver being Amended: 10/01/07

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for

which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The Department, implements procedures to comply with Idaho Code §56-118. This statute requires that the Department implement methodology for annual review and determination of reimbursement rates to private businesses providing developmental disability agency services, mental health services, service coordination and case management services, residential habilitation agency services and affiliated residential habilitation specialized family services. A report of the results of this annual analysis is submitted annually, by November 30, to the Joint Finance-Appropriations Committee and the Health and Welfare Committee of the Senate and House of Representatives.

The annual analysis of reimbursement rates that is required by Idaho Code §56-118 includes solicitation and survey of service providers for information and comment in order to establish rate determination methods and develop fair and equitable rates.

Pursuant to 42 CFR § 447.205, the Idaho Department of Health and Welfare gives notice of its proposed reimbursement changes by publishing legal notices throughout the State to inform providers about any change. Additionally, payment rates are published on our website at www.healthandwelfare.idaho.gov for participants

to access either themselves or through their guardian.

Waiver service providers will be paid on a fee for service basis as established by the Department depending on the type of service provided. The Bureau of Financial Operations is responsible for rate determinations. The Department holds hearings when we promulgate rules to describe the reimbursement methodology. As described below, most waiver service reimbursement rates were developed based on Personal Care Service rates and then increased or decreased based on the qualifications, supervision, and agency costs required to deliver the waiver service. This is in the methodology currently in effect.

Please see below for services and Reimbursement Methodology information:

Residential Habilitation

The initial rate was set based on Personal Care Service rates and then increased or decreased based on the qualifications to provide the waiver service, what sort of supervision was required, and agency costs associated with delivering the services.